840 Carolina Street
Sauk City, Wisconsin 53583-1374
(800)-362-3309 Fax (608) 643-2564
www.unityhealth.com

Please Complete Entire Form in BLACK INK.

EMPLOYEE APPLICATION

EMPLOYMENT INFORMATION:

Name of Group/Employer:	Hours Worked Per Week:
Employment Status: ☐Active ☐ Retired ☐LOA:	Requested Effective Date of Coverage:
Date Employed:	Plan Requested: ☐HMO ☐ POS ☐ PPO ☐ Other:
Type of Coverage: ☐ Employee ☐Employee and Spouse ☐Employee and Child(ren) ☐Family	
Reason for Enrollment: ☐New Hire ☐Marriage date (__/__/__) ☐Loss of other Insurance ☐ Add a dependent ☐ Name Change	

EMPLOYEE INFORMATION **(Please do not use abbreviations or nicknames on this application)**

Applicant's Last Name First Name MI				Social Security Number	
Mailing Address	City		State	Zip Code	County
Date of Birth / /	Gender ☐M ☐F	Marital Status: ☐ Single ☐ Married ☐ Divorced	Primary Language Spoken: ☐ English ☐ Spanish ☐ Other	Home Phone # ( ) _____ Work Phone # ( ) _____ Cell Phone # ( ) _____	
*Primary Care Physician (PCP) and Clinic: **If you want Unity to assign you to a Clinic or a PCP, indicate "**ASSIGN**"*			Current Patient? ☐Y ☐N	Applicant's E-Mail Address:	

APPLICANT INFORMATION – Please list all other Members to be covered:

Dependent Name (Last, First, MI)	Mailing Address if different than subscriber.	SSN#	Relation -ship	Date of Birth	Gender	*Clinic and PCP Name	Current Patient?
					☐M ☐F		☐Y ☐N
					☐M ☐F		☐Y ☐N
					☐M ☐F		☐Y ☐N
					☐M ☐F		☐Y ☐N
					☐M ☐F		☐Y ☐N

OTHER INSURANCE INFORMATION:

Will you or any of your dependents continue to have *other* insurance, including Medicare, after the Unity Health Insurance effective date of this policy? If Yes, complete:
Name(s) of Insured _____ Employer_____
Insurance Company_____ Subscriber # _____ Group # _____
Effective Date of Coverage _____ Insurance Company Phone # _____

Do you or any dependents have medical coverage that has ended or will end within 30 days? If Yes, complete:
Carrier_____ Phone #_____ Subscriber #_____
Effective Date of Coverage _____ Termination Date _____
Names of those covered under policy:
Are you or a family member currently involved in a Workers Compensation case? ☐**Yes** ☐**No**
If Yes, indicate family member involved and start date/accident date:_____-
_____
Workers Compensation Condition:_____
_____
Insurance Co Name:_____
Insurance Co Address:_____
(where claim is sent) _____
Insurance Co Phone:_____
Group#:_____

Effective Date:_____Term Date (if applicable):_____

WAIVER of GROUP COVERAGE:

I elect not to apply for the Group Health Benefit Plan coverage: ☐ Employee ☐ Spouse ☐ Children

Reason for waiving coverage: *(please see back of form for additional information)*

☐ I/we will be covered by a health benefit plan which provides similar benefits. Name of Insurance Co.:_____
☐ I/we will be enrolled in a similar health benefit plan offered by my employer. Name of Insurance Co.:_____
☐ The annualized premium contribution to be paid by me for Unity would exceed 10% of my annualized gross earnings.
☐ Other _____.

I understand that enrollment and/or eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting Unity to obtain medical records from health care providers who have treated me, my spouse or any dependents applying for coverage under this application. If medical records are needed, Unity will provide me with an authorization form. To the best of my knowledge, all statements and answers in this application are complete and true. I understand that any misstatement or omission may result in denial of a claim and/or rescission of coverage.

Date:_____ Employee Signature:_____

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.